SENATE COMMITTEE ON
JUDICIARY

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Room 412
The Knott Building
Tallahassee, Florida

VOLUME 2 OF 3
(Pages 175 - 255)

SENATOR J. ALEX VILLALOBOS, CHAIR
SENATOR DAVE ARONBERG, VICE CHAIR

SENATOR CHARLES W. "CHARLIE" CLARY, III
SENATOR DURELL PEADEN, JR.
SENATOR ROD SMITH
SENATOR DANIEL WEBSTER

To receive testimony from invited parties regarding Medical Malpractice.

Reported by: Susan Willis, RPR, RMR, CRR

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SENATOR VILLALOBOS: Madam Secretary, please call the roll. And ladies and gentlemen, please take your seat.

(Roll call. A quorum was present).

SENATOR VILLALOBOS: Senator Campbell has sent a letter of excusal. He is in federal court today. The federal system doesn't not recognize Chapter 11.111, which grants members of the Legislature legislative stay. So he has no choice but to be in federal court. And, therefore, he is excused from this Committee hearing.

We are going to take up where we left off yesterday. Mr. Roth was testifying. We asked him to step aside so that a physician who had to return to his practice this morning could testify. And I thank Mr. Roth for stepping aside and allowing him to do that.

You're still under oath, and I would like to take up where we left off. I believe the line of questioning was regarding the amount of payments that an attorney can accept or not accept, and what the percentage is, and that's where we were. Senator Smith, you were following that line of questioning, and you're recognized to continue.

MR. SMITH: Thank you, Mr. Chair. Actually, I pretty much completed that. I would like to, if I could continue with this witness and move into another area involving bad faith.

SENATOR VILLALOBOS: Absolutely.

EXAMINATION

BY SENATOR SMITH:

Q Mr. Roth, I think your testimony was 26 years that you have been practicing in the area. We've had a number of complaints, and I have had concerns regarding the operation of the bad faith law in Florida.

There has been an allegation that from time to time it operates to be a gotcha, by which people are not given enough information. And without that information, either they have to make a decision to go ahead and settle; and if they don't settle, to run the risk of paying what's called an excess judgment.

I know you're way more familiar, Mr. Roth, with this whole system than I am. We have proposed some changes in the area of bad faith that would make much more of the information driven on the front end, the requirement that plaintiffs provide more information, that certain exercises take place, and that the length of time be expanded, I think to around 210 days.

And, Mr. Roth, you know there has been iteration after iteration, so whatever it is, it is. But I would like you to react to the criticism of the bad faith system in Florida, and also whether or not -- hasn't this, in fact, been a gotcha from time to time, by which the insurance companies don't have

enough information, and they have to settle the lawsuit or face dire consequences of an excess judgment?

A Well, first of all, Senator, Members of the Committee, I do not believe that the bad faith system and laws result in, quote, gotcha litigation, because the courts have, in a number of areas have cautioned lawyers about trying to engage in surprise tactics and gotcha litigation.

Bad faith is a body of law which protects the insured, the doctor in this case, or homeowners or automobile drivers from practices by insurance companies that are just what they are described as, bad faith, refusing to settle cases, when under all of the facts and circumstances, they both should have -- and I think that's lost in the debate.

The word should have means they have facts, they know what the liability is in the case, what the causation is in the case and what the damages are, and that they could have settled the case, meaning that regardless of what the policies limits are, whether they are woefully inadequate or not, the plaintiff was willing to accept that money to settle the case.

In malpractice cases in particular, there has been, since the mid-eighties and certainly since 1988 --

Q Yesterday Senator Campbell asked this question, and I claim no expertise in this area, but he said that bad faith is actually a protection for the insured; is that correct?

A That's correct.

Q So in this scheme of medical malpractice, is the beneficiary of bad faith, at least if it's operating correctly, supposed to be the doctor?

A Correct.

Q There has been some discussion about the doctor bringing the lawsuit as opposed to others bringing the lawsuit. What's the benefit -- in Florida, you can bring on behalf of a plaintiff a bad faith claim, which essentially serves to the advantage of the doctor, correctly?

A Correct.

Q All right. Go ahead. I am sorry, I interrupted you. I just wanted to clarify that because not everybody knows this area, and I certainly don't.

A Right. And based on the common-law and the bad faith statutes, the case can be brought by the insured or by the person who will be collecting the excess judgment.

But going back, Senator, to your question about information. Certainly since 1988 in the medical malpractice field, the physicians and hospitals get notice of a claim 90 days before a lawsuit can even be filed.

During that 90-day period, what happens, typically now -- and I know that the Legislature is looking at trying to strengthen some of this and get more information earlier. What happens now is first we get a call.

We do the investigation. We gather records, find

witnesses, and try and determine is there a case or not. We then have to have a notice letter, and a verified, sworn-to, just like we're all being sworn yesterday and today, sworn-to affidavit from the expert attesting to the fact that reasonable grounds exist to bring the claim.

Once that letter is sent and received by the defendant, then there is to be an informal exchange of information over 90 days.

We get a letter in every case where there is insurance involved, and sometimes when there isn't, from lawyers representing them, maybe 20 items that the insurer would like to have in order to evaluate the case.

We provide that information as we go through the 90-day process. So there is a tremendous amount of information that is available even before the lawsuit gets started.

Q Mr. Roth, let me stop you there for a second, though. One of the criticisms I have heard is that while it is true that you have to have an expert letter, and you have to send an appropriate notice, that that can be pretty skeletal; and that it can be so skeletal as to give virtually nothing other than just notice that someone has found that it's below the standard of care, and that you intend to bring that action.

I mean, shouldn't we, in fact, strengthen and put more onus on the plaintiff's lawyer and on the plaintiff's expert to set forth their theory in the case and to set forth what's

going on so -- right now all you do is you really can get a pretty skeletal outline from, from an expert, and that seems to meet the statutory requirement. Isn't that true?

A Yes, sir. As the statute is written now, you can write a broad-based letter and a broad-based affidavit. We have no problems with strengthening those requirements and making the notice letter more detailed and the affidavit more detailed.

We would just ask if that's going to be done on the front end, that when cases are denied on the back end, that we, for our clients, get substantially similar information. Because what happens -- and this does happen on occasion, when you get, when you do get an affidavit back denying the claim, and a competent and credible expert has been retained on the other side, any good lawyer will question the wisdom of the decision to go forward and will check the opinion and the facts that the defense is setting forth, because the last thing you want in malpractice litigation is to go down another year or two or three, spend the kind of money that has to be spent to prepare the case, and not be able to make a recovery for your client. It is not good for them. It is not good for the lawyer.

Q Mr. Roth, while you're on that, we have heard a lot about frivolous lawsuits, and my understanding yesterday is that we finally have imploded the idea in Florida that there's

a lot of frivolous lawsuits in medical malpractice. From your practice, isn't it true that a tremendous amount of resources have to be set aside by a law firm if they are going to entertain a medical malpractice lawsuit?

A Yes.

Q The reality is, is it not, that the lawyer's decisions to take a medical malpractice lawsuit is usually a fairly conservative one in light of the fact that you know the resources, both in terms of time and money you're going to lay out?

A The edict in our office is when in doubt, err on the side of turning a case down.

Q You have heard the other side talk about this yesterday. I want your reaction. Are we having frivolous lawsuits -- you have been practicing in this area for 26 years. Are we having frivolous lawsuits filed in the medical malpractice area in the State of Florida?

A I have no evidence that's the case at all.

Q Do you believe that to the degree we continue to open up the requirement or, excuse me, strengthen the requirement to put things on the front end, that that even guarantees more, that costs are going to be more front-end loaded; you're going to have more obligations as you discover information about the case, and that ought to eliminate any question about somebody taking anything but a fairly strong case?

A That's correct. Particularly, one of the changes dealing with having to have perhaps multiple physicians review cases to line up with the specialties of each doctor will add considerable cost to the pre-suit investigation of a case. And I think that that's true, Senator, that's what will happen.

Q You have heard the term --

SENATOR VILLALOBOS: Wait, wait, wait one second.

EXAMINATION

BY SENATOR VILLALOBOS:

Q Let me apologize for interrupting, but since we are on the topic now of multiple doctors looking into, into these cases, yesterday there was some testimony from the Florida Medical Association that the problem with medical malpractice is not an increase in frivolous lawsuits, but rather dishonest physicians, the hired guns, so to say, that come into the State and testify against their own members and perhaps not give forthcoming information.

Tell us how you choose an expert, and how an expert is tendered to the court. In other words, you know, what's the process? You offer them up. You know, is there, is there a little pamphlet that says these are hired guns available, you know, have gun will travel, and this is my fee?

How does that work? And when you go into court, and you present them as an expert, how does the other side, how does the defense attorney -- you know, what line of questions

would they go into of that physician before they are actually tendered as an expert?

A I am glad you stopped, because that was a compound question, and I got the three parts of it, so I'll go through it.

Q Well, that's a good question.

A It is. First of all, how does someone select experts? What you try to do is find credible people who the other side will respect, because that sets an important tone for the case as you're beginning it.

Credibility comes from either years of experience in the field, whether they are in the State of Florida or out of the State of Florida. It's not uncommon to look to academic institutions, where people have good reputations.

Q Try it.

A Okay. Okay. It's not uncommon to, when you're dealing with specific medical conditions that are at issue, to look through medical literature that's published in what's called referee journals, meaning before you can get an article published, someone has to look at it to make sure that it's a reliable -- the work has been done reliably and is scientifically valid. And so those are, those are some of the ways that you go to find expert witnesses in the medical malpractice field.

Once you have an expert, and you go to a court to put

them on, it could take anywhere from 10 to 15 -- and I have taken as long as half an hour to qualify an expert to testify, where you go through their background, training, experience, publications, hospital affiliations, you know, their clinical practice, their research activities, their teaching activities, whatever it might be that will convince the court that they have the requisite background and qualifications to, to testify.

Q Well, and that isn't accepted as gospel. Opposing counsel has an opportunity to question each and every part of that?

A That was the third part of your question, which was: What, then, does one do when one is defending against such a witness, whether we are cross examining a defense expert, or they are cross examining ours?

There is a process by which you do research. You find out what work they have done before. You may read what they have published to see if it's consistent with what they have said under oath, either way.

You can get into issues related to how much money they are being paid, how many times they have testified, for which side they've testified. All of this stuff is subject to fair cross examination. And notwithstanding what some people may think about the jury system, the jury system does a pretty good job when six people collectively get together and sit through

the case and, you know, who is credible and who isn't, who is relying on facts and who aren't?

And having said all of that, most malpractice cases, in my judgment, are determined on the facts. What is it that happened? What was done and what wasn't done? Who talked to whom about what? And were standards of care properly met? Experts are important because then you have to have experts to testify in the standard of care. The cases are fact driven.

Q Mr. Roth, let me ask you a question, and I'll get back to you, Senator Smith. But the Florida Bar disciplines its attorneys when there is questionable behavior on their part.

The Florida Medical Association testified yesterday that they would like to also have an opportunity, when there is one of these physicians, if in their opinion -- and they are doctors, so they know what we are talking about -- a physician has testified dishonestly or misled the court, and it has resulted in an adverse verdict against one of their members, why should, why should they not be afforded the same opportunity to discipline those physicians?

I think one of the things that they talked about was perhaps have them certified prior to testifying, you know, from their own boards to make sure that their qualifications are up to par. What's wrong with that?

A What they are talking about is requiring every single expert only in medical malpractice cases, who is going to

testify, who resides in a state other than Florida -- and, believe me, it's not that easy to get a Florida physician to testify in cases against Florida physicians.

There still is a, somewhat of a conspiracy of silence that exists, particularly in the local territory where you're at. But what they would like to do by creating this licensure requirement is put a very chilling effect on out-of-state, qualified doctors who are willing to come into Florida and tell it like it is.

If they've got a problem with a doctor who they believe has given untruthful testimony in a court of law, there are remedies in the court of law to deal with that. And I don't know of very many circuit court judges who, if someone comes in post-trial and says, you know, this Dr. Smith -- and I don't mean it that way -- this Dr. Smith gave this testimony, and now we can establish to you that it's not, not a matter of opinion. As a matter of fact, he or she has lied. I don't know of any circuit court judge who is going to tolerate that kind of behavior.

And I think there are some examples in the case law where judges have reversed verdicts because they have found things to be untruthful. And that's, that's the way the system should work. The bigger problem, Senator --

Q Let me interrupt you there a second. Is there -- so that's a remedy. If a physician is found by the court to have

given untruthful testimony, a remedy is reversal of that judgment; is that correct?

A Correct.

Q Do you have any idea as to how often that occurs? I mean, are these cases, you know, more than 50 percent of them reversed?

A No, sir.

Q Five percent? Ten percent? I mean, what --

A No, sir, it doesn't happen. But there is a bigger problem with expert witnesses going on this country right now, and that is both state and nationally, the state medical associations and the national medical associations are clamping down on doctors who are willing to, you know, testify and tell the truth and testify in malpractice cases for plaintiffs. And there is specific proof of that that we have.

And it's shameful. It shouldn't be happening. You would think that if they want the good cases to be in and the bad cases to be out, they would be more than willing to assist in ferreting out the cases, but they are going in the opposite direction.

SENATOR VILLALOBOS: Senator Smith.

SENATOR SMITH: Thank you, Mr. Chairman.

EXAMINATION

BY SENATOR SMITH:

Q Back to the issue of bad faith. I think I had stopped

you at some point, and I probably will do it again, because I think it's important we understand what's at stake here.

Our current proposal would expand the time, I believe 210 days after service of a lawsuit, after the 90 days, that's a proposal that's sitting there.

I know from the look on your face it's not one of these that trial lawyers are enamored. We also had a second tier, if you will, that has been kind of driven by the requirement that the way that time can be shortened is that if you provide the insurance company with more information, if you make your experts -- disclosure experts for -- not only disclose them, but they are deposed, that if the plaintiff has the opportunity to have his deposition taken, and you have taken the deposition of the defendant, and we've had not arbitration but mediation, the mediation has taken place; that if all that has happened, then within 30 days, whichever of those two events is the earlier, our idea was that this would drive more people to provide more information quicker, and thus start the clock on bad faith if, in fact, bad faith is the goal, which, hopefully, it's not. What the goal is, is to get the information out there, get a proper response, assessment of the case. React to that, if you would, to that proposal and how that stacks up with what we do today.

A First of all, the goal. The goal is if there is a liability case that exists, a meritorious case with significant

injuries and damages, the goal for our clients is to try and get the case resolved early. Because by definition, it means that their damages are going to exceed the policy limits that are available. So under any consideration of it, they will be under compensated.

Some of what I have heard today is going to drive the costs up significantly, which diminishes the amount of money that our clients will receive. And it is for those reasons that we have problems with adding formalized early discovery of expert witnesses into the mix.

When a bad faith letter is written to an insurance company, if that letter does not contain the facts upon which liability is based, and the facts upon which causation is based, and the facts upon which the damages are being claimed, then that bad faith case, down the road, should it emerge, is meaningless.

You can't hide behind the facts, causation, or damages, and write a letter that says, "I represent Mrs. Jones. Dr. Smith has a $250,000 insurance policy. Pay me the money."

It doesn't work that way. And so to the extent that, that part of it is looking at formalized discovery of expert witnesses, I will tell that you the battles they have fought in the hearing rooms around the state are when should experts be deposed, and what's the order that they are going to be taken

in?

And every defense lawyer who goes into a hearing like that with me says we want to do the experts late. And the reason they want to do the experts late is in a lot of these cases, the facts are complicated and need to be discovered over time when it comes to sworn testimony.

Q This proposal, then, to the degree that in your assessment would drive -- or the assessment of that branch of this debate that you represent, to the degree that it would drive costs up on track two is why we left track one in place, and that is, you don't have to do that.

You can allow 210 days, or whatever that number turns out to be. We have talked about 180 days. You can allow that time period to pass. Then you have specified factors.

So, I mean, I have heard this argument before, that, well, it's going to drive the costs up. But, ultimately, that's going to be the decision the plaintiff's attorney makes, because you have the first tier. You have that first tier that simply says at the expiration of this period of time, if it takes place, then there is some jeopardy. But, of course, under those factors, one of the factors is: Does the insurance company have fair information to make a decision about? Because, I mean, that's what we're really after. They have to have a chance to evaluate the case; you agree?

A I agree they have to have a chance to evaluate it.

And what I'm saying is that they have a lot of information. The problem with -- one of the biggest problems with bad faith litigation or exposure in this case right now, in this state is what Mr. White testified to yesterday. And that is whatever the percentage is -- and I don't know the specific numbers -- but a significant percentage of physicians who do carry insurance only carry $250,000 of liability limits.

That is a significant problem in this case. And why do they -- why do they carry those limits? Because the Legislature, back in the eighties, said that we should have some financial responsibility, although it has a gaping loophole in it right now.

But the number is $250,000. So if a doctor looks at the law and says, "What is the minimum amount of insurance that I should carry?" And the State has said 250, and that's a policy they feel they can have, they can buy, they can afford, that's what they buy.

And I can tell you that that number is a difficult number even as a threshold number for taking one of these cases based on the costs that are involved.

Now, if you want to strengthen pre-suit, if you want to give more detailed information, if you want to give, you know, access to treating physicians with unsworn statements, where an opportunity to be present is there, where the treating doctors can help the insurance company evaluate the injuries

and the damages that are involved, we don't have a problem with that in terms of more information.

But this notion that they don't have information early to make an evaluation, to me, is not accurate. In all honesty, Senator -- and I've said this before. I can sit down with good defense lawyers and good insurance people at the end of 90 days, and within a 10- or 15-percent range in a meritorious case, we will know what the value of the case is, and we will know what the settlement value of the case is. But there are disincentives for insurers to pay cases early. You want to add some teeth to it, add pre-judgment interest.

Q Mr. Roth, one other area I want to touch on is currently Florida has, under Chapter 766, an arbitration provision. I won't go through the whole provision. You know it better than all of us combined.

Basically it says $250,000, if the parties agree to go to arbitration. And apparently the Legislature thought arbitration was a pretty good idea, and that's why they imposed it, and we have used it. And I understand that if the doctor offers it, and the plaintiff won't go, then there is a $350,000 cap on non-economic damages that exists. Is that kind of accurate?

A That is accurate.

Q Okay. We currently have a proposal that has been talked about, certainly been advanced by the Governor for

$250,000 caps. You do agree that under the arbitration cases as interpreted in St. Mary's, it is per claim -- per claimant is the way it's been. The proposal of a $250,000 hard cap then would essentially mean that arbitration, in my view, would be gutted. It would be gone. No one would go to that because arbitration actually would be worse than what you would face under the current cap structure. Am I right in that?

A You are right. There would be no reason to hold on to arbitration if there is a $250,000 non-economic damage cap.

The arbitration scheme that came out of the 1988 Legislature said in exchange for not having to prove liability and causation in cases, and to get damages paid early, that was the tradeoff. So that if the defendant wanted to offer arbitration, and if the plaintiff accepted it, you went down to arbitration, gave up your right to a jury trial. If you rejected it, you could get up to $350,000 in non-economic damage claims.

Again, I come back to the same problem in bad faith exists with respect to the arbitration. You will hear all kinds of reasons why it's not used more often --

Q I want to ask you to comment on that.

A Why it's not used more often, by the, by the physicians in particular, because hospitals are a different story. But physicians in particular, again, it revolves around the fact that most physicians -- whatever the statistical

numbers are will be borne out by the facts. But if, indeed, most physicians, 50, 60 percent only have $250,000 in coverage, and you have got a serious case where the damage is serious, and they want to try and go through the arbitration, their hands are tied.

They can't offer to arbitrate if it's a $250,000 non-economic damage claim, because the arbitration scheme also says that you get your economic damages; that there are limitations on the lost wages that can be recovered. You only get 80 percent of your lost wages, but you are supposed to collect your medical expenses, past and future.

And when you have serious cases, and I think we have established these most often are serious cases and certainly not frivolous. The total amount of the damages that the claimant is entitled to, even under the arbitration scheme with caps, are at a level where the physicians can't pay the arbitration award. And that's why, in my judgment, in my experience, you don't see physicians offering arbitration where there is $250,000 in coverage intact.

Q Thank you, Mr. Chairman.

SENATOR VILLALOBOS: Senator Peaden.

EXAMINATION

BY SENATOR PEADEN:

Q You said that only 80 percent is paid, is that only in that statutory status of arbitration?

A Yes, sir.

Q In looking at the scheme we have laid out before us, particularly the proposal Senator Pruitt has offered as far as the expert panel, do you think that -- and using that particular scheme, the costs would be prohibitive as far as you having to have the expert witnesses, having the pre-trial work, the pre-suit work, do you think it would be prohibitive in cost in our system?

A Well, certainly adding another layer, if you will, into the process already will inevitably have some clause attached to it. But it all comes down to: What will the screening panel require in terms of information, whether it's live or by documents and records? What kind of presentations are they going to want to have? The devil is always in the details, Senator, and that's what it's going to depend on.

Q Mr. Roth, you know, we have heard that most of these suits, if they are legitimate and non-frivolous, it would cost as much as $100,000 to evaluate them, call the expert witnesses, and gathering the information.

In the efficiency of the entire system, looking at Senator Pruitt's proposal with the panel, do you think that would add any efficiency as far as building on your data you already have, as far as justified cases, non-frivolous, based on valid evidence, breach of care, standard of care?

A If the panel as instructed are made of up people who

are truly objective and will give fair evaluations of the cases, then there may be a legitimate tradeoff between the cost and the information and the benefit to be obtained.

Q In offering the patients the rights, and procedurally, the correct procedure -- you know, we should be concerned about the patient, not the doctors and the lawyers and insurance. Do you think this would be a more efficient way than was offered 25 years ago when we had a similar system? Or do you think we should change it? Or do you think we should totally delete this procedure?

A The system that was in place in 1975 to 1980 of medical mediation panels proved to be terribly inefficient, and was ultimately declared unconstitutional as applied five years later.

The current panel approach is different because it doesn't require the amount of time that was allotted for medical mediation, nor what was, what was then, in effect, the preparation of a mini-trial. And I cut my teeth on those mediation panels when I started practicing in the mid-seventies. And they got very expensive, you know, to do.

Again, I come back to the devil is in the details, and exactly what's going to be required is another layer.

Personally, from my standpoint, maybe it's going to help, you know, some small group of cases that are out there. But we already know that there are no frivolous lawsuits in

malpractice. And we already know what the investment has to be into the cases, you know, before you start them. And the pre-suit process, if strengthened, is probably as good as anything to ferret out cases.

Q Mr. Roth, and what Senator Smith was asking about bad faith, in your heart of hearts, in justifying what we do here today for the patients, do you think it would be a better system for them and the physicians to have to go back to common law or preserve the statutory bad faith law we have in place now?

A I think if, if the Legislature deems in its wisdom to limit bad faith claims to common law, I think that's acceptable. But I do think that the right of action has to rest either with the insured or the injured patient getting an assignment of it.

Q As far as the system, would you change anything in the way of third-party opportunities or standing there?

A No, I would not change that law, because there is a risk of -- I'll use a strong word, called collusion, between insureds and insurers, if the insured only has the claim. Things can happen that would be awful for our clients in that regard.

Q Thank you.

SENATOR VILLALOBOS: Senator Aronberg.

SENATOR ARONBERG: Thank you, Mr. Chair.

EXAMINATION

BY SENATOR ARONBERG:

Q Thank you, Mr. Roth, for being back. Are there other states that have the same bad faith laws as Florida? In particular, are there other states who allow third-party plaintiffs to sue in addition to allowing the insured to sue because of bad faith?

A I believe there are other states which have third-party actions.

Q Do you have an idea of how many?

A I do not know the number.

Q Justice Alderman in the Boston Old Colony case, that was one that extended the common law of bad faith, he dissented and said that if the insured settles, the plaintiff will receive no more than the policy limits. But if it does not, the plaintiff may end up with both the policy limits and an excess judgment according to the law, common law, bad faith rule induces a plaintiff not to settle.

In addition, we have heard testimony that the common law, bad faith rule or statutory, for that matter, induces a defendant to settle more often.

Do you agree with the statements that the way that the courts have interpreted bad faith induces a plaintiff not to settle because they can get a larger judgment if they take it to court? And it induces the defendant to start settling cases

that may not be as meritorious, because they are fearful of a larger judgment?

A The Florida standard jury instruction on bad faith says that the insurer both could have and should have settled the case.

How can an insurer, quote, could have settled, if the plaintiff wasn't going to accept the money? They can't have it both ways. You can't have an inducement not to settle if you're saying pay the policy limits. You can't offer to settle for the policy limits if you're not prepared to accept the letter that says, "We accept your offer."

So I don't believe that that analysis is correct, and I disagree with it. And that's why it is part of the dissent and not part of the majority opinion.

SENATOR VILLALOBOS: This is the last part of the last part of the last part.

BY SENATOR ARONBERG:

Q And the last part of my question is about the defendant -- the insurance company, you say that they also have to settle more often because they worry that they will be hit with a larger judgment if they don't settle cases. So our bad faith rule forces insurance companies to settle cases that aren't very meritorious?

A Okay. I keep coming back -- and I don't want to sound like a broken record. The jury instruction says they could

have settled the case and they should have settled the case. The should have includes the evaluation of the liability, causation, and damages in the case. And what the bad faith laws do are protect the insured, because I don't want it to get lost.

A judgment that's entered in the State of Florida, when a claimant wins a case, is a judgment that is good for 20 years and can be renewed for 20 years; and that the obligation of the person who has been sued doesn't end with their policy limits.

And under the law, whether it's malpractice or anybody else who has a judgment, they have a right to use the laws of Florida to collect the judgment. And the bad faith laws protect the insured against bad faith claims handling. And those words, I mean --

SENATOR VILLALOBOS: Anymore questions for Mr. Roth? Thank you, sir. Gail Parenti. Please raise your right hand. Do you swear or affirm that the evidence you're about to give will be the truth, the whole truth, and nothing but the truth?

MS. PARENTI: I do.

EXAMINATION

BY SENATOR VILLALOBOS:

Q Please state your name and your occupation.

A My name is Gail Parenti. I am an attorney with the

firm of Parenti, Falk & Wass in Corral Gables, Florida. I am here on behalf of the Florida Hospital Association.

Q Okay. You have been employed in that capacity for how long?

A I have been an attorney with Parenti & Falk for approximately 10 years, and I have been a defense attorney for 20 years.

Q You have been representing the association for how long?

A Since February of this year.

Q Okay. In your experience, can you tell me how many medical malpractice claims originate in an emergency room?

A Without having statistics that I would have to stand by under oath, I can give you a rough estimate on that. In my estimate, it is approximately 10 percent of the cases that are hospital based would have originated in the emergency room, roughly.

Q So as an educated guess, 10 percent of the medical malpractice cases that are filed, are you talking about the ones that are filed in court where there is actually --

A In my sense, in my experience, I would include both cases that are initiated by a notice of intent and a case where a complaint is filed, because there are many cases that are settled during the pre-suit screening process. So I think it's only fair to look at the cases that are started by a notice of

intent and not draw a distinction between the notice of intent and the complaint being filed for that purpose.

Q You're representing the Hospital Association, right?

A (Nods affirmatively).

Q Are you aware of any emergency rooms that have closed as a result of an increase in the number of frivolous lawsuits?

A The truth of the matter, Senator, is I don't have personal knowledge of that, nor would I, either in my role as an attorney representing hospitals, or in the position that I have been asked to, to adopt with the Florida Hospital Association.

I don't get involved with the operational, administrative details. I would not be in a position to have personal knowledge of that. I'm an appellate attorney. I study legal issues.

Q Okay. And so does your client come to you and tell you one of the problems we have with legal issues that are facing us is that we are shutting down emergency rooms, or we are shutting down a certain type of practice because of X law, and we need to change it, or ask you for advice as to how to change that law?

A Senator, I'm not really sure how close you're getting to asking for information that is attorney-client privilege. I will tell you that in a general sense, I know that hospitals as a general rule are concerned about overall issues of emergency

care, and that is making sure that specialists, on-call specialists are available to provide the on-call care that's needed to provide emergency services.

I do know that that's a general concern. Beyond that, I'm not in a position, either with the Hospital Association or as an attorney representing hospitals from the appellate perspective, to have any further personal knowledge of that.

Q Well, I do know how far I am going into the attorney-client privilege, and I think I did not ask you whether or not a particular client has given you some information or not.

I mean, what I'm trying to establish is whether or not you're in a position where a hospital asks you or tells you, "Look, these are some problems that we have." And what I'm trying to get at is not what strategy you use one way or the other, okay, nor proprietary information.

What I am trying to get at is whether or not you, as the attorney that represents the hospitals, the Hospital Association have seen, you know, litigation -- I mean, that's what an attorney does, litigation -- that would suggest that hospital emergency rooms or a particular type of practice is closing down as a result of lawsuits. I mean, you're the attorney, and you're who they would go to; isn't that correct?

A I am an appellate attorney. And in my role as an appellate attorney, normally, I get cases as they have gone through the process. I'm not involved in operational issues at

that level.

Usually, there are other attorneys. You know, the hospital may have business attorneys, or the trial attorneys would be involved in that. I am telling you it is my position as an appellate attorney, I am not close enough to those issues to be able to answer the questions that you're asking.

Q Thank you. Fair enough.

SENATOR VILLALOBOS: Dr. Peaden.

EXAMINATION

BY SENATOR PEADEN:

Q Let's state it another way. Since you're an appellate attorney, what percentage of your appellate work, directed at patient care, is derived from patients that initially are presented in the emergency room, subsequently become patients in the hospital, go through the referral process, and a part of the litigation system?

You said 10 percent of the cases occur in the emergency room. If these are patients that are stabilized, passed through the emergency room, and go to surgery, go to the intensive care unit, what percentage of the litigation might be involved there?

A I still would go back to probably 10 percent, 10 percent of the cases -- I think it's a rough estimate, and I haven't done any calculations -- would be cases that originate in the, in the emergency room.

I am not trying to distinguish between cases that involved pre-stabilization care, and cases that the patient is then thereafter admitted and seen by, you know, consultants, and goes on to be treated, but roughly 10 percent of the cases have an emergency room component.

Q So, generally, you're saying that we are dealing with the same population, the same 10 percent that cause you problems with litigation in the emergency room are the same 10 percent that cause you problems with litigation in the intensive care unit or in surgery or wherever?

A I am sorry, I didn't understand your question. The cases -- I thought the question was are there -- what's the percentage of cases that originate in the emergency room.

Q Right.

A I don't have a basis for saying whether they go to the floor, whether they go to any other place in the hospital. Roughly 10 percent originate in the emergency room, and they can go any number of places thereafter.

Q You imply that there was a problem of back-up call or stabilization of the patient with a back-up consulting physician after they hit the emergency room.

And I'm trying to get at whether we have more problems because we have an inadequate number of doctors that will accept a patient on a consulting basis, is that a problem, is that a problem with them receiving malpractice insurance? Is

that a problem with approving them for services and access to care? Or is this a phantom problem? Or do we have a problem with quality of care at that level of intensity, tertiary type care?

A I think, once again, that was about five questions. I don't think it is a phantom problem. But because of my particular role and, you know, I am an appellate attorney, I see particular types of issues. I don't have the hands-on knowledge to be able to testify under oath exactly what the source of that problem is.

I do have a general sense from my experience, from having been involved with this process so far, from representing hospitals, that there is a problem on the hospital level with making sure that there's adequate care or adequate coverage for the emergency room, to make sure that there are physicians who are willing to come in on call to provide the emergency services, and that it's not just two -- I mean, where it might have been five that rotated, now it's just two.

I mean, I can't point to a specific example, but I am aware as a general matter that there is a concern that, that emergency rooms don't have the coverage in the emergency room that they used to have.

SENATOR VILLALOBOS: One, one second, Senator Peaden.

EXAMINATION

BY SENATOR VILLALOBOS:

Q Since you are aware of the problem of the staffing emergency rooms, can you, can you tell the Committee whether or not sometimes the hospital chooses to perhaps staff a different specialty versus another one, not because of lack of physicians, but because one specialty might be move profitable to the hospital than another?

A I can't answer that question, nor would I be in a position to answer that question. I just --

Q Thank you.

A We have no ability to answer that.

Q Thank you.

SENATOR VILLALOBOS: Dr. Peaden. I interrupted you.

SENATOR PEADEN: That's okay.

BY SENATOR PEADEN:

Q With the concern about obstetrical services being closed in various hospitals, do you see that as a problem with malpractice, or a problem with changes in population, or changes in reimbursement, in the sense that it's a business decision that's made because funds for reimbursement aren't there? Or is it a business decision that's made because of the problem recruiting physicians because of malpractice crisis?

A Senator Peaden, again, I have no ability to answer that question, especially not under oath. I don't represent OB/GYNs. I do know that my own physician no longer delivers babies, but I can't testify as to what his reasons are. But I

am simply not in a position to be able to provide that kind of testimony.

SENATOR VILLALOBOS: One second, Senator Clary.

EXAMINATION

BY SENATOR VILLALOBOS:

Q Are you aware, in your capacity as representing the Hospital Association, whether or not hospitals have some type of contractual relationship with their physicians so that they are unable to go to another hospital and practice at another hospital?

In other words, they don't want competition someplace else, so they have a contractual relationship with a physician, and they are told you can't go someplace else, some other hospital in Florida and practice. Are you aware of that?

A Senator, I'm not. Again, I'm the appellate attorney dealing with legal issues in the medical malpractice arena. I do not get involved with the hospital on the operational, business type, and in contractual relationships. And I'm simply not aware of that. Certainly, the hospital could enter into any variety of contractual arrangements, especially if it needed to get access and have physicians. But I just am not in a position to be able to answer that kind of question.

SENATOR VILLALOBOS: Okay.

EXAMINATION

BY SENATOR PEADEN:

Q So restricted covenants have not raised to the level of appeal? I mean, there's not concerns about restricted covenants at your --

A I can answer that, I have never dealt with an issue like that in 20 years of my practice, so I just -- it's not something within my universe of knowledge.

SENATOR VILLALOBOS: Senator Clary.

SENATOR CLARY: Thank you, Mr. Chairman.

EXAMINATION

BY SENATOR CLARY:

Q I have got a few questions related to the Hospital Association, which you may or may not be able to answer. But I thought I would ask, anyway. Do you know how many companies sell hospital professional liability insurance?

A I don't know the answer to that question.

Q Do you know if insurance is available for the hospitals?

A I know from as a general sense, from representing hospitals, that they are concerned about the availability of insurance that's -- the market that is available to them, and it is becoming more expensive and is decreasing.

I know that as a general matter, both on representation of hospitals and from what I have learned in this process, but I don't know the operational details.

Q Do you know, does the Hospital Association endorse one

particular carrier over another?

A I would have no way of knowing that. But -- I would have no way of knowing that.

Q Thank you.

SENATOR CLARY: Mr. Chairman.

SENATOR VILLALOBOS: Senator Clary, do you have anything?

SENATOR CLARY: She can't answer the question, so I don't have anymore to ask.

SENATOR VILLALOBOS: Senator Peaden, do you have anymore?

SENATOR PEADEN: Yes, sir.

EXAMINATION

BY SENATOR PEADEN:

Q Would you possibly know in the sense that their coverage might have been restricted, have the hospitals resigned themselves to the size of the policies for malpractice?

A My understanding is that many hospitals carry a very high level of self-insured retention, and that as insurance becomes less and less available and more and more expensive, that SIR keeps creeping upward. But that's the information that, that I have from a general sense.

I can't break it down hospital by hospital. But as a general matter, the SIR that the hospital has to carry had been

creeping upward.

Q And going back to the emergency room, has there been any change in policy as far as what would be considered an independent contractor versus a contracted physician in another status, or an employed physician, as far as who furnishes and what is required of the emergency room physician or the emergency room group?

A Again, I am not involved with hospitals on that kind of an operational level. Typically, the hospitals that I represent contract with a group. Typically, the contracts ask the hospital, the emergency room physicians to carry a million dollars in liability insurance. You know, beyond that, the operational details are beyond the scope of what I deal with.

SENATOR VILLALOBOS: Senator Peaden.

BY SENATOR PEADEN:

Q One more question. In order to secure the consultants and the back-up doctors to take the emergency room physicians, do most of your hospitals pay those physicians to be on call, or do they furnish their care free or their backup?

A It's -- and this is -- it's my understanding that in most instances as a part of being -- of having staff membership, the doctor agrees to provide on-call services, but I don't know.

I don't think that there is any additional compensation involved. The on-call specialist is entitled to

bill for his services. Much of that is going to be, you know, not recoverable, but I don't believe the hospital provides any compensation separate and apart from what they would ordinarily be able to cover.

Q Thank you.

SENATOR VILLALOBOS: Senator Smith.

MR. SMITH: Thank you, Mr. Chair.

EXAMINATION

BY SENATOR SMITH:

Q Ms. Parenti, in your practice in the last 20 years, you have specialized in the appellate practice. Was there a time in which you engaged in trial practice?

A Yes.

Q Do other members of your firm engage in medical malpractice defense at the trial level?

A The 14 or 15 others lawyer do.

Q So you are the one that's worked your way up to writing the briefs, and they are still doing the trial work. But you, obviously, as the appellate lawyer, advise them and are aware of the cases that they carry on, and the issues that arise in medical malpractice for your clients which are HCA and Tenet, which are both relatively large for-profit hospital corporations, correct?

A Correct. I want to clarify that our firm also represents one of the statutory teaching hospitals, and we also

represent Baptist Hospital System, which is not for profit.

Q So let me go to something that I would ask you -- I think you gave an answer. We've had statements that have been made over the last two days regarding the concept called frivolous lawsuits.

You have heard -- in fact, before you testified today here you have heard the testimony of Mr. Roth that there is an economic deterrent to frivolous lawsuits, certainly that has been in place since the last change in medical malpractice.

Yesterday you heard a number of people say that there were not frivolous lawsuits. You were here, and you observed these proceedings throughout. In your practice and the practice of medical malpractice, have you, have you observed an explosion of frivolous lawsuits, say, in the last two years?

A I want to be very careful in how to answer this question, because I know how much focus has been placed on this. There was some discussion yesterday about the semantics of what do we call frivolous --

Q Let me cut you off for a second and tell you why I am going to use this term.

SENATOR VILLALOBOS: Let me cut you off, Senator Smith.

EXAMINATION

BY SENATOR VILLALOBOS:

Q There has been a lot of focus, and we didn't bring

that focus. Your clients have brought that focus. And other groups have brought it, but your clients have participated in that, and that's why we are trying to get facts out.

Now, yesterday the testimony was that -- the sworn testimony was that there are not a large number of frivolous lawsuits. As a matter of fact, there aren't many at all.

Senator Smith -- correct me if I am wrong -- Senator Smith asked whether or not you have a knowledge other than what you heard testified to here.

A Senator, I have been asked here to tell the truth, the whole truth, and nothing but the truth, and that's what I would like to do. The term frivolous lawsuit is a term of art among the legal profession. I am very cautious in using that term. Okay?

There is another sense of the word frivolous, that is walking-around frivolous, what somebody who is a man off the street would say is a frivolous lawsuit.

Q Which is the problem that we've had, and that's why we are getting down to it now.

A And I could probably get a summary judgment in a classic frivolous lawsuit in, you know, the legal sense of the word. But I can't generally get a summary judgment, even if it's walking-around sense frivolous.

What I have seen and what I have witnessed personally, I would not characterize necessarily as an explosion. But I

would say that I have seen an increase in the types of cases that I would call walking-around frivolous. And those are the cases that in the grand scheme of things don't -- your ordinary man off the street would say, "That's just crazy." And I have seen that, and we have that in our firm.

We have cases against hospitals which, even though there is a surgical error, there is a claim that's brought against the hospital for negligent credentialing, shall we say, to try to make the hospital liable for the surgeon's negligence. We still have to spend money to defend those cases.

That's not a case that can be captured by pre-suit, but it's a case that we have to defend. I've seen in the last two or three years in particular an increase in cases which I believe are a direct by-product of what we have seen happening in the nursing home industry, because there is such a close alliance between the injuries that are sustained in nursing homes and in hospitals.

We have seen -- and I know you know more about this probably than I do. There has been an explosion --

Q I doubt that.

A There has been, there has been an explosion in the settlement and verdict ranges for nursing home cases and specifically cases involving decubitus ulcers. Nursing homes are not the only ones that get sued for decubitus ulcers.

Hospitals have seen an increase in the number of cases that are brought related to nursing home cases, because there might be a patient that's in the nursing home, and then goes across the street to the hospital, goes back to the nursing home, goes back across the street to the hospital.

Someone out there has figured out that if there is a lot of money to be made over here on the nursing home side, they might see if they can make it over here on the hospital side. So we have seen in an increase in cases involving claims for pain and suffering related to a pressure ulcer that may not have had anything to do with the major condition that the person is in the hospital for. We have seen --

Q The flip side of that, though, is have you seen an increase in injuries, though?

A The injuries -- I have not seen an increase in injuries. What I have seen is an increase in the instance of bringing those cases. And what I have seen and what really got me focused on the issue of set-offs and the need for reform in that area is because what we have seen is a situation where there is a nursing home, a hospital, a nursing home, and a hospital, and it's the same pressure sore that's in the nursing home, the hospital, the nursing home, the hospital.

The plaintiff collects $500 from the nursing home -- $500,000 from the nursing home, $700,000 from the hospital, $600,000 from the nursing home, and then still comes against

the hospital.

I don't know if I did my math right, but the case I'm thinking about, the plaintiff has already gotten $2 million for the same pressure sore, and I'm not sure I can get a set-off.

To me, in the walking-around sense of the word, continuing with the lawsuit in that circumstance where there's already been a full recovery for that injury is walking-around frivolous. So there has -- there is a problem with that.

There are other cases of which the lawyers in my firm bring to me a pre-suit affidavit that the plaintiff's affidavit is skimpy, and the letter is skimpy, and they say, "But they left this out, and they left that out. And, you know, can we challenge this in some way?"

And my experience as an appellate lawyers leads me to tell them most of the time that there's really not a basis that they can do that; that if there is an affidavit, the court will say it's allowed to go forward, even though we believe that affidavit really doesn't support the claim, and that claim may really not have merit.

And so we have seen, in that sense, the existing pre-suit mechanism not work as well as it should because of, you know, that particular defect, because claims are allowed to get through that perhaps just skeletal, skeletal support that get into the system.

Q Now, the example that you used where a person might

have gotten up to $2 million already, was that a case that was settled or a case that went to trial?

A That actually is case that is pending in my office right now where there were three prior settlements, and the court is going to have to determine whether or not I get a set-off for any of that amount. And under the current law, it is very questionable whether I will get a set-off at all.

Q But there was a settlement three times?

A Yes, there was a settlement three times with other people, and now they are continuing against the fourth hospital, the fourth defendant for the same injury.

And this is where the economic motive and the economic consideration of bringing a case breaks down. Because if you're looking only at a single defendant, and you're looking at the economics of bringing a case against a single defendant, you may not be as likely to bring a frivolous lawsuit.

If you've got, if you've gotten geared up, and you're going against somebody else, the economics -- that part of it breaks down as the universe of potential defendants expands, and then it becomes easier to bring those other marginal lawsuits.

Q Okay. That is your experience in your law firm, but then are you saying that when the Florida Medical Association testified yesterday that there is no increase in litigation, are they incorrect?

A I can only testify as to what my experience is in my law firm. I would not attempt to characterize anybody's testimony here as correct or incorrect. I can tell you under oath what my experience is in my law firm.

Q Thank you.

SENATOR VILLALOBOS: Senator Smith.

EXAMINATION

BY SENATOR SMITH:

Q Thank you. I want to go back just for a second. First of all, the scenario you painted, which is a scenario which allows for recovery from nursing homes separate from the medical malpractice, that is what the law is today, correct?

A Yes, it is.

Q It provides for that, correct?

A Yes, it does.

Q A lawyer who had a client who was injured in a medical -- what he believed to be a medical malpractice setting, but also had a complaint against a nursing home, under today's scenario, those cases about which you complain, which may be a probable policy, that lawyer would not be pursuing a frivolous lawsuit; that lawyer would be practicing malpractice if he does not exhaust going against each available defendant, correct?

A That's where, that's where I think we part ways with what is walking-around frivolous.

Q Let me stop you, let me stop you right here, Ms. Parenti. Let's talk about frivolous. You're a lawyer. You have been practicing 20 years. There is a definition of frivolous in the law. It's recognized in the law. It's the one you practice under. Have you seen an explosion of frivolous lawsuits as it's defined in the law?

A No, I have not.

Q As it's defined in the law, a frivolous lawsuit leaves you recourse to do several things, including going to the Florida Bar, including certain action you could take with the circuit judge. Has there been any expansion in your practice of using that tool, either under Chapter 57 or any provisions under 766 against plaintiffs who bring lawsuits which you have found to be frivolous or your firm has found to be frivolous?

A I can tell you I have invoked 57.105 successfully once.

Q In 20 years?

A Well, in the last 10 years, in this area in particular. And as far as 206, we have -- especially in the beginning days of pre-suit, we file motions under 766.206 with some regularity. But our experience was that the courts truly did not really take those seriously to the point where it became -- I wouldn't say futile, but in a cost-benefit analysis, it just didn't make sense to go forward with it. So we have used 766.206 and tried to use it, ultimately became

frustrated because it was ineffective to do what it was intended to do.

Q Has there been -- have you noticed -- for a moment, you talked about summary judgments. Has the rate of summary judgments being entered against plaintiffs dramatically changed in the last two years?

A No.

Q Up or down?

A No.

Q Has the quality of lawsuits in terms of the quality of the lawsuits which have been brought dramatically changed in the last two years, say, from what you observed five years before that?

A Yes.

Q In what way have they changed?

A I would give exactly the same example as I gave you before. What we are seeing is an increase in that claim that probably wouldn't have been brought before, because in the context of everything that was going on with that patient, it really wouldn't make sense. But those claims are being brought now, and the quality of those claims is not what I have witness to.

Q The Task Force on nursing homes, when they last met and concluded, Senator Argenziano was a member of that, and she notes that they were unable to get a handle on frivolous

lawsuits and, in fact, determined not to provide in their report that there was an excess of frivolous lawsuits in the area of nursing homes, that other entity of which you have spoken. Do you agree or disagree that frivolous lawsuits have increased or decreased in the area of nursing practice?

A You know, in the area of nursing home cases in particular, I can't speak to that, especially for the last five, seven years, because our firm made a decision not to handle nursing home cases after a certain point in the mid-1990s, probably followed on the heels -- I lost the Spillman decision. Shortly after Spillman was decided, our firm stopped representing nursing homes in nursing home cases, so I've not been involved in the nursing home litigation directly. But what I have seen is how it has spilled over into the hospital side.

Q I want to switch to an area and ask you about, you have used the term set-offs in some of your discussion. I would like to talk you very, very briefly about that.

Let me see if I can set the stage for this, as I understand it, for which you are clearly an expert in your practice.

Number one, hospitals, though we have a comparative liability situation, normally the hospital's involvement, the great number of times, I am assuming, the hospital is involved would be more a vicarious liability situation than a

comparative liability; is that true?

A That's not accurate.

Q Okay, tell me why that's not.

A The hospital --

Q Let me back up. In the emergency room setting, I was actually prefacing that question.

A That changes the whole scenario.

Q Okay.

A In the emergency room situation, yes, the hospital is typically involved in the case on an allegation of vicarious liability and not a comparative fault situation. The comparative fault comes into play in settings other than the ER setting.

Q Currently, you get a dollar-for-dollar set-off, I mean, the hospital gets a dollar-for-dollar set-off for any monies that were received by the plaintiff from the physician in the emergency room. Is that true?

A Yes. And in a vicarious liability setting, because we are liable for the same damages, if they have received $500,000 from the physician, then we would get a set-off, if we went to trial, for the amount that is paid by the physician.

Q In terms of -- your testimony was that at least at the hospitals that you represent, that there is -- a million dollars is the standard practice policy for emergency room physicians that's being currently purchased; is that correct?

A In my experience, most of the hospitals I represent do have that kind of a relationship.

Q So is it safe for me to say or for this Committee to conclude that essentially the first million dollars, the first million dollars is typically not on the hospital, but is on the physician, or is against the physician policy?

A Typically. In a straight vicarious liability situation.

Q We have been talking about or considering -- and I think Senator Lee and others, we have been talking very early regarding possibly reducing the exposure of physicians in an emergency room. And we talked about our current proposal is that would be a $250,000 exposure.

If we change the $250,000 exposure being the doctor's total exposure, and you still get that set-off, the reality is, as I understand it, if we went to $2 million, you would now have an additional -- your client, the hospitals, would now essentially reach down $750,000 lower into the liability bucket, if I am making myself clear. Is that correct?

A That's exactly right.

Q If we set it at a million dollars for the emergency room and $250,000 for the ER doctor, then essentially the $750,000 reach would be the entire reach for your client, correct?

A Correct, but it's not necessarily -- it's not going to

be the same amount, because there are going to be more cases that are between 250 and a million, a lot more cases, than there are which is -- that come typically within our exposure, which would be the million to two million. So it's not like you just drop down and dollar for dollar have the same exposure. In dropping down, we will pick up a lot more cases than the hospitals are currently exposed for, and that is a significant, significant exposure.

Q In the area of closed claims -- and I am going by this, and I want to ask you if you agree with this. In the area of closed claims reports, we see less than 1 percent of the cases against hospitals exceeding $2 million. Is that consistent with what you would have seen in your practice? Once again, these are ER cases.

A ER cases, some of the biggest cases we have had to handle have been ER cases. Generally, that would probably be consistent. There were only a few cases that exceed the $2 million.

Q And, similarly, while it drops down a couple of percentages, it is still somewhere above 97 percent of the cases don't even exceed $1 million. Would that be consistent with your findings?

A That is consistent with my experience. I haven't done a study on it, but my experience is our exposure is between that million and 2 million, which is a lot fewer cases that are

between 250 and a million.

Q Without revealing any trade secrets or client confidentiality, could you give us a range of the coverage that hospitals typically carry, from your experience, policy levels that hospitals carry?

A It depends on -- from the hospital system to hospital system. Typically, you will see a million to 2 million to 5 million self-insured retention. And when I say self-insured retention, it's important that everybody knows that for every emergency room case that comes within that SIR, that's, that's payment that the hospital makes.

Then they get excess insurance or insurance to come in over that, perhaps up to the $10 million level, and then they'll have excess from, say, 10 to 25, and then perhaps there will be another layer from 25 to 50 to cover the hundred-year case.

And the policies that are above the SIR that I've reviewed in my practice, typically are not written on a per-occurrence basis, but it would be an aggregate, so that perhaps each claim that goes against that policy then depletes the coverage that is available for other patients.

So that's what I have been seeing recently. And the SIR has been creeping up, and then there may be layers of reinsurance in there that, you know, is beyond my level of understanding. But, typically, they are -- you know, there's

some rural hospitals -- I don't represent rural hospitals, but certainly rural hospitals may not have the ability to get that. But I'm in a major metropolitan area, and the nature of the hospitals that I represent present that kind of insurance scenario.

Q You have heard what's called the Texas plan, and I am using this by something that deals with various cells, silos, categories. I've heard every phrase used, because none of us know what the adequate phrase is. But it essentially treats the physicians one way, the hospitals in a separate line, and others, HMOs, if you will, kind of in a third line.

As I understand this from the set-off perspective, for it to work -- and we're talking non-economic damages here -- your set-offs are dollar-for-dollar within the silos, but those set-offs would not translate against another silo; is that correct?

A I have spent a lot of time studying this particular problem since the Texas plan has been put forward, and given what's in the House plan and the Senate plan, trying to see how set-offs would work, to achieve the goals of making sure that the cap on non-economic is enforced so the total amount of non-economic damages is not exceeded, to make sure that the defendants pay their fair share of liability, but only their fair share of liability, and to make sure that the total amount of the recovery that the plaintiff gets at the end of the day

from all sources, from economic and non-economic damages, does not exceed the amount that's set by the jury as reduced by the caps.

My belief, after having studied all of that, is that the way that this would work in a silo system, would be that the court would first apply the caps on economic -- well, actually, first the court would determine what is the relative percentage of fault, because there may be cases where the defendant's relative degree of fault does not meet the cap.

So the first thing the court would do is determine the relative degrees of fault. And then if that party's relative degree of fault exceeds the amount of the cap, and the amount collectively within that silo exceeds the aggregate that is applicable to that silo, it is necessarily for the court to do what I have called -- because as I'm sitting here by myself trying to figure it out -- because an intra-silo adjustment to make sure the total recovery does not exceed the amount that is established as the aggregate for that silo. And then you would repeat that process for each of the three silos.

Then at the end of the day, you need to revert to a different calculation, because it is important to recognize that the plaintiff's total recovery should not exceed the amount that's established by the jury verdict as what the case is worth, as affected by the caps.

So it would be necessary to add up the amounts that

all of the defendants at trial are liable to pay as determined by that formula, and compare it to the amount that the plaintiff has already gotten in settlement.

If there is an overlap, then our traditional set-off should come into play. And the amount that the jury -- that the plaintiff would receive should be no more than what the jury has said the case is worth as reduced by the set-offs.

This is a methodology that makes sense to me, and I have spent many hours, over -- especially the last weekend, working within different types of scenarios to see if I could understand if there was a way to achieve balancing all of those three goals, and I believe there is.

Q Well, thank you, Ms. Parenti for those responses on set-offs. It sounds like to me your learned law firm and everybody else will have plenty to litigate if we go to the silo system, because the audience was very clear on that explanation. Thank you for it.

But as I do understand it, your set-offs are intra-silo, as opposed to inter-silo for the system to really work on non-economic damages.

A Non-economic damages calls for intra-silo adjustment, so that if the aggregate is $500,000, you look at all of the amount the plaintiff recovered for non-economic damages to make sure that doesn't exceed the $500,000.

Q Thank you.

SENATOR VILLALOBOS: Senator Peaden.

SENATOR PEADEN: Thank you, sir.

EXAMINATION

BY SENATOR PEADEN:

Q Ms. Parenti, you mentioned that there's been an increase in hospital litigation, because what's been spawned, as far as litigation against the decubitus ulcers in the nursing home, the nursing homes always say that my patient never had a decubitus until they went into the hospital. Is it because the hospitals are being indicted, so to speak, by the nursing homes, you're having the problem?

A I don't know whether it is the chicken or the egg. All I know is they are closely related. The phenomena are closely related against physicians who treat that population.

Q In that group, there is an increase, but could you clarify what you mean? Now, this is liability. If the physician has a procedure in place in his orders that says, "Move the patient. Take vital signs at certain hours. Make sure they have pillows under them," or whatever else. Now, what you're talking about, what percentage increase in the hospital litigation is there?

A You know, I don't have the data that gives -- that would allow me to give you under oath a percentage. I can tell you that I have personally touched five or six cases in my firm last year with exactly that scenario, and I have given two

presentations to hospitals and hospital groups on the interrelationship in what's happening in nursing home litigation and what they were seeing in decubitus litigation and how it affects care there.

Q Okay. Getting around -- this is the problem. Is this a problem that is addressed under traditional malpractice, breach of care of the physician, failure to identify the problem? Or is it a procedural problem and a nursing problem for the nursing home? The cases you mentioned, was the physician -- was there a problem with breach of standard of care?

A In four of the cases I have mentioned, it's the hospital that's named, and we are representing the hospital. In one of the cases that I am, that I am referencing, our client is a physician, and there is a breach of the standard of care that is alleged as to the physician.

Q But in the majority of the cases, in the majority of the cases where litigation has increased, it's not an indictment of the physician or the standard of care of the physician?

A I can't say that. All I know is that the -- in my experience, in the cases of that nature that I have dealt with, it has been the hospital that's pointed to rather than the physician.

Q So that wouldn't fall under the standard in our

statutes, malpractice?

A Well, it is malpractice against the hospital, because you're looking at the nursing and whether the nurse -- whether the nurse violated the standard of care, because the standard of care applies to nursing also.

Q We are trying to kind of focus on breach of standard of care and expert witness. And it's, as you said, you don't know which comes first, the chicken or the egg. But, you know, in trying to narrow down and focus on what we are going to do procedurally for physicians, you know, if you say the majority of the cases are with custodial-type care, which should be excellent, too, is not with physicians failing to identify and diagnose a problem; is that true?

A Thank you for letting me make that clarification. Nurses are healthcare providers, too, and they are subject to the Medical Malpractice Act. And the hospital's liability is primarily based on nursing care and the breach of the prevailing standard of care there. So it is absolutely a part of what we are dealing with here.

In most cases, when you're dealing with a nursing issue, when it comes to a pressure sore, it may be failure to do a care plan. It may be, you know, any number of things. It may be poor documentation. The same thing may happen to the physician. But in both cases we are dealing with a claimed departure from the prevailing professional standard of care.

Q But the increasing number of cases is not because of the breach of the standard of care of the physician?

A I can't say that. What I have seen has been nursing care, but which is part and parcel of what we are talking about today.

Q And it would not be addressed under the same statute?

A Yes, it is. But I'm sorry, Senator, it is, because nurses are healthcare providers included under the malpractice laws under Chapter 766, subject to the same provisions.

Q Thank you.

SENATOR VILLALOBOS: Anymore questions? Thank you very much. Mr. George Meros. Thank you for coming. Please raise your right hand. Do you swear or affirm that the evidence you're about to give is the truth, the whole truth, and nothing but the truth?

MR. MEROS: I certainly do.

EXAMINATION

BY SENATOR VILLALOBOS:

Q Please state your name and your occupation.

A George Meros, and I am an attorney.

Q And you're here representing whom?

A I represent the Florida College of Emergency Physicians.

Q Once again, thank you for coming here and testifying for us today.

A My pleasure.

SENATOR VILLALOBOS: Dr. Peaden.

EXAMINATION

BY SENATOR PEADEN:

Q Mr. Meros, we've heard your testimony a number of times. What do you think is the major problem with the emergency room physicians? Is it the problem with litigation, spawned by the fact that they have inadequate backup to cover and stabilize those patients?

Is it a problem with inadequately trained physicians? Is it a problem with inadequate availability of physicians because of medical malpractice? Which of those three would you think would be the tantamount thing we need to address today?

A Senator, it is both a combination and more fundamental than that. And let me start with the very most fundamental element, and it spans this whole discussion about frivolous lawsuits and non-emergency care as well. And that is what has happened in the last 10 years is increasingly a situation where doctors, emergency room and otherwise, are sued by virtue of judgment calls that are different in, in -- not only specifics but in nature than other tort lawsuits.

So the first and most important element is you have to understand that the tort system and the legal system is not, is not well designed to second guess close judgment calls where there is no necessarily right answer. And I would suggest to

you that that Dr. Shalala, in the testimony that she gave and others, or her commentary in the Task Force is very probative. Secondly, what has happened --

SENATOR VILLALOBOS: Wait a second.

EXAMINATION

BY SENATOR VILLALOBOS:

Q Explain that a little bit further, what you just said.

A Certainly.

Q I think what you just said is that the problem is that it's very difficult to reach a conclusion in medical malpractice cases.

A One thing -- yes, sir. And one thing that has not been addressed factually, legally, or otherwise, sufficiently, I would suggest, is what the Task Force heard a lot of testimony about and what people like Dr. Shalala was concerned about, and that is --

Q Mr. Meros?

A Yes.

Q Dr. Shalala is not here.

A I understand.

Q And we want to ask you specific questions, and we want an answer if you know them.

A Certainly. If I misunderstand, please tell me the questions you would like me answer.

Q I don't want to put words in your mouth. I just want

to make sure that I understand what you're saying.

A Certainly.

Q One of the elements, you said the fundamental element is that it is more difficult to understand, you know, a conclusion on a medical malpractice case, and that is one of the problems; is it not?

A No, sir. No, sir, that is not the case.

Q And that is why I am asking, because I don't want to put words in your mouth. I just want to make sure that I understand what you're saying.

A First, in response to Dr. Peaden's question as to what are the causes -- as I understood the question, what I am trying to answer --

Q Right.

A What are the various causes for the liability concern, liability problems with emergency room physicians?

Q Right.

A The first thing I am trying to do is get at something that fundamentally affects emergency rooms and affects all medical practitioners --

Q You say there is one fundamental element, or the first one, I want you to explain that first one.

A And that element is that medical decisions and litigation relating to medical treatment is different and far less probative than it is in non-medical tort cases.

If you run a red light, the testimony is relatively clear. Did you run the red light? Did you not?

In medical-related litigation, it is not a matter of whether you ran the red light. It is if, in fact, you had done this procedure two hours ago, or within two hours rather than four hours, would the person have lived or died? That is a very different analysis.

Q Okay. Let's go back there because, in my mind, that is not a different analysis. I'll tell you why, and I would like you to explain the difference.

A Sure.

Q When the question is whether or not you ran a red light or not, unless the person, you know, is wasting everybody's time going to court, I assume when they enter a plea of not guilty, they claim that, no, I did not. So the evidence is put forward to whomever is going to make the determination, if it's a bench trial, a judge, or -- a red light is not going to be before a jury, but let's assume it is.

A Right.

Q It is a matter of, you know, if you believe one side or the other, because a red light, it was either red or it was not.

A Right.

Q Okay. Well, on a medical malpractice case, also, you know, two hours will make a difference. And then, again,

evidence presented on both sides and a person -- either a jury, or a judge will make a determination whether or not they believe the evidence that is presented before them, whether that was a good idea or not.

A Senator, that is exactly the point I am trying to make, though contrary to the suggestion in your question, and that is, it is an easy answer. If you ran a red light, you're liable. It is a fundamentally different question whether if you did it within two hours, or you did it within three hours, or whether did you it at all, in medicine, whether that is negligence.

And this system, and our basic tort system is far less capable of making reasonable decisions and fair decisions with physicians about those judgment calls than a situation that it is critical, and that is if you ran the red light, you made a mistake.

Q Let's use a different example then. Let's go -- since you used the red light example. You know, in criminal law, that is rarely clear cut. As a matter of fact, as Senator Smith said, it is usually a yellow light, not a green or red light. So, in other words, I mean, I just want to make sure I understand, and I don't want to again argue philosophy with you, because you're entitled to your opinion.

A Absolutely.

Q Okay. But one of the things that you're saying is, it

is -- perhaps it is a less certain science; is what you're saying?

A It is a far less certain science, and that science is wrapped up in judgment calls, where either judgment oftentimes can lead to a bad result, death, injury, otherwise. And even when that -- even when you make a decision where it could be good, it could be bad, you can still be sued, not because experts are lying, but because we are doing it in the context of a system where a jury is supposed to decide should that person have done that?

Whether or not a doctor should do that is a far different story than whether you ran the red light. And one thing that's wrapped up in all of this -- and I would encourage the Senate to look at this and ask the opponents of the forum this question, whether or not there is any data, anywhere, in medical malpractice that suggests that the tort system, the same system that applies to red lights, to doctors, improves patient outcomes. Because, Senators, it does not, and that is what the data shows. And I am telling you that under oath. I am telling you that based on the Harvard study that I will provide you. That's, number one, a fundamental problem in medical malpractice.

Q Okay. So it's that it's an imprecise science?

A It is a particularly imprecise science with a system that is particularly imprecise in being able to tell doctors

what they truly should have done that would have been made a difference.

Q And who is it that confuses then the imprecise science?

A It is not a matter of confusion. It is the fact --

Q Excuse me, it is, because when you're on a jury, which, you know, are regular, mere mortals.

A Right.

Q And they are listening to testimony --

A Yes.

Q -- you know, these guys are -- usually they are not a physician. As a matter of fact, rarely are they a physician. But they are people dragged off the street and told they can't go to work for two weeks because they have to come to trial.

A Right.

Q That is the system that our founding fathers, you know, began.

A Right.

Q Okay. They need to sit there, and they are enlightened by testimony on both sides. On the one side, you claim that there is this imprecise science. Who is it that confuses those jurors?

A It is not a matter of confusion of the jurors, and I absolutely do not criticize the jury system or jurors whatsoever.

What I criticize are legal standards which this Legislature can improve that do not permit jurors to make the best possible decision because of the difficult nature of judgment calls in medical malpractice actions.

When you say and when -- look at the jury instructions. Jury instructions for medical malpractice are the same for who ran the red light.

Should that doctor have known that but for those actions this person would not have been injured in error, those sorts of judgments calls in medical malpractice are very different.

It doesn't permit the most -- the fairest and most careful analysis by jurors in this type of setting. And that's one reason why medical malpractice is different.

Q Okay. How would it be fairer?

A One way to be fairer is to be realistic and to understand that because medical malpractice is different, because these are judgment calls where there is often no right answer, that many of these reforms are fundamentally necessary. And it is a very reflection of these problems that -- why we are here today.

One of the problems now is a patient-doctor relationship is incredibly important. It is one based on trust. And the more information given and the more information received, the better the outcome.

When you put this sort of system, imperfect, one-size-fit-all system into that sort of relationship, where a bad result is immediately going to be second guessed, then you not only have imperfect results which do not lead to better patient outcomes statistically, but you also --

Q Mr. Meros, let me ask you something. Would you agree that whoever it is, when you go to court, there is always a victorious side? Wouldn't you agree that whoever is on the losing side is going to question the outcome? I mean, I --

A For different reasons. For different reasons. You know, who ran the red light, a juror might have believed John Smith because he had a better view of the red light, and --

Q Wait a minute. When you're talking about a witness, when you're talking about a case of whether or not some procedure should have been two hours ago versus now, I understand, you know, more questions.

However, to use the red light analogy, a case where you go in for, you know, your -- you broke your left arm, and they cut your right arm off, that is a red light, and that is kind of hard to argue with; isn't it?

A And I wouldn't argue that, and the reason I wouldn't argue that, because that is so far the exception, that that's not what the essence of this debate is about.

Q Well, okay, let me stop you right there, because that is a question that I am grappling with.

A Certainly.

Q When we are talking about limits, some type of limits, and I promise you, I am not being adversarial. I am really grappling with this internally.

A Absolutely. I welcome the dialog.

Q When there is that exception, which does not, I agree does not happen often, but it does, when there is that exception, shouldn't there also be an exception in the law for the amount of damages that can be given, you know, in that exceptional case?

A That, obviously, is for this body to decide. I certainly think that people who make severe mistakes like that should, should pay compensation for the people that are -- that suffer those. And I don't dispute that for a second. What I dispute fundamentally --

Q I understand, and I'll let you finish that. But, like I said, this is a question that I have been grappling with internally.

A Right.

Q And it is the case where there is exceptions, because the determination I have to vote on shortly, I think, will include or not include whether or not we should have exceptions.

A Senator, let me follow up on that, because the next part of the answer is important. And, again, it hasn't been

discussed. And that is, if you have many of these reforms, what you are going to have is a situation where that is done less and those mistakes are done less.

The irony of this entire situation is that the opponents to reform want the status quo, and then they bring before you tragedies that occur with the status quo.

And this Senate, I encourage to look into the reality that one of the reasons why these things happen is because of the degradation of the relationship between patient and doctor, the second-guessing of the tort system that has not improved medical outcomes, and reforms that just may well cause those tragedies to go away or be diminished significantly.

Q Mr. Meros --

A And that is a big question.

Q I would really like you to answer my question.

A I'm trying.

Q And that is: Do you believe that exceptional circumstances, there ought to be exceptions in the law?

A I think that -- I doubt it very seriously, because if you have exceptional circumstances, all you're doing is wrapping into the situation an uncertainty which means that you are going to have the same sort of, the same sort of degradation in the relationship, the same sort of problems we had before.

If we do not get to the point where we recognize

status quo needs to be changed in order to improve care, then we are not going to do the benefit that we need to do. And exceptions swallow the rule and that is what happens.

Q Mr. Meros, your argument, not mine, was there is the red light example and how that is clear cut, the red light is clear cut, and then there is: Should a physician have done this two hours before or not? I agree that that occurs.

I further agree, or I would submit to you that that occurs not only in that, but in criminal law and in all other types of law. Because at the end of the day, you're only talking money here. In criminal law, you're talking, you know, liberty and in some cases, life or death.

Okay. Now, there are, you know, sides, extremes on both sides. But I am asking you, when there is a red light in medical malpractice, and that is when you were not supposed to cut off my right arm and you did, okay, now one of the things that this Legislature has to do is it has to write in whether or not there will be exceptions.

A I understand.

Q So I don't see how, if you use -- your argument was the red light argument, and saying that that will, you know, swallow up the whole debate. You know, my question to you is a simple one. I have to vote on whether or not there will be an exception in those extreme circumstances.

A And my answer is you should vote no to exceptions,

because creating exceptions for the purposes of money damages is not going to reduce the number of those cases. If you want to have a provision --

Q The person whose arm was cut off would feel a lot better; wouldn't they?

A Not necessarily.

Q Well, I would.

A If that doctor is punished for gross negligence, that is the sort of punishment that may well make a difference. But I'm telling you, Senator, if you look back 20 years, statistically -- and this Senate wants facts. The imposition of damages does not improve medical outcomes in all types of cases.

Q Mr. Meros, what I am talking about is not punishing the doctor. What I am talking about is someone who no longer has an arm or lost their sight. Okay. And, you know, besides them wanting to punish the doctor, they also want to be -- you know, have a wrong righted.

Now, what you're advising me to do, though, is not to have any exceptions whatsoever.

A Right. A wrong righted does not mean, in my view, unlimited pain and suffering damages. A wrong righted means reasonable compensation.

Q I didn't say unlimited. If there is an exception, but it is a higher exception, in other words, let's assume for

argument's sake that we have a cap, but we have exceptions to that cap under certain circumstances --

A Right.

Q -- that will still have a limit, is it your testimony that we still should not do that for the person who was wronged?

A Yes, sir, because it will not improve patient care. Just because we have a situation where you're talking about full economic damages -- you're talking about hundreds of thousands, if not millions of dollars in pain and suffering, in your instance. That additional money will not improve patient care whatsoever.

All it will do will be to continue a system that has created these problems in the first place. And what I am saying is, there are ways to get justice, and one way to get justice is to punish those who commit gross malpractice.

And I am not suggesting for a second that should be done. But what I'm saying is do it in the context of real facts. And whether this system makes a difference in patient care, and it does not, and you have -- and I would suggest to you, sworn or unsworn, in the last eight months, you have haven't heard any testimony, any statistics that suggest that this system improves patient outcomes, and that's one of the reasons why the Task Force discussions and Dr. Shalala's discussions were so important.

Look at NICA and look at other situations. NICA is a recognition that medical situations are different. That is a legislative policy that occurred long ago. The administration of NICA and the implementation of it can be a mess. But it is a legislative recognition that medical situations are different.

Now, Senator, if I may go to the second element of your question, and the second thing, specifically with regard to emergency care, in addition to that, is when you have emergency cases, as you well know, the first thing that happens is you have a patient that, number one, can't choose where he or she is going or which doctor is going there, and the doctor doesn't choose the patient. And, oftentimes, you have the patient that cannot talk.

You have may have a patient that has any number of illnesses. You may have a patient that doesn't do follow-up care or has had -- or doesn't take care of himself or herself, and you have the most split-second, difficult relationship that you can have in how to treat this person who comes in, by definition, with a life-threatening emergency or with an emergency.

SENATOR VILLALOBOS: Senator Peaden.

EXAMINATION

BY SENATOR PEADEN:

Q So I hear you're implying we need to improve patient

care, and what we've done or what we proposed to do will not improve patient care. Do you think we should change the evidentiary standard? Are you satisfied with it for emergency rooms? Or do you think it's too liberal? Or what do you think about the standards?

A You're talking about the Good Samaritan statute?

Q The evidentiary standard we have for emergency room cases in medical malpractice.

A In existing law, the evidentiary standard has in practice been, unfortunately, meaningless. It is -- it says the words "reckless disregard."

It has been interpreted, because of the language itself, to be negligence. And, again, that is a legislative recognition of 15 years ago that there should be a difference.

This Senate and this Legislature should, in fact, make a standard that does have a higher burden of proof, that is meaningful, that takes into account the reality of this situation, and makes it much, much more difficult to obtain a verdict against emergency physicians.

SENATOR VILLALOBOS: Senator Peaden, anything further? Senator Smith?

MR. SMITH: Thank you, Mr. Chairman.

EXAMINATION

BY SENATOR SMITH:

Q Mr. Meros, currently the standard is for emergency

rooms reckless disregard. There has been some complaint that reckless disregard has been -- I'll use my words -- has been watered down in some interpretations.

Do you agree that in the emergency room setting, for the reasons that you set forth, that we ought to continue to use reckless disregard as the standard for liability?

A Certainly not the reckless disregard standard that is in there. It is nothing like a reckless disregard standard. It should be --

Q That is in where?

A That is in the Good Samaritan statute presently.

Q Okay.

A It says reckless disregard, but then it defines reckless disregard as negligence. And, Senator, all you have to do is look at the case law to see how it's been defined. It has been of no help to the emergency safety net at all.

Q You would, you would agree that reckless disregard, there should be standards; you would simply say we ought to strengthen the definition of reckless disregard?

A Well the words reckless disregard have no meaning. The question is: What would the jury hear? And the jury should hear that the standard is substantially higher than negligence -- and I know the Senator has produced some language like that. My only criticism of that language is that that's all it says, substantially higher than negligence, which for a

jury instruction, doesn't tell them what it needs to tell them.

It needs to go on to say something more to give them the sort of real, tangible rule that would show that it is a much stronger standard.

Q We have talked about -- you have complained that the one-size -- I am using your statement -- that a one-size-fits-all tort system does not work well for medical malpractice.

A Right.

Q Would you agree that one-size-fits-all is a problem when we try to apply the tort system to medical malpractice? But you also talked about the essence of the debate we are here about today, but the essence of the debate in large part is about caps; isn't it?

A The debate is wide ranging and has any number of different components. Let me give you --

Q Let me ask a question here about caps for a moment.

A Okay.

Q The question I have about caps is: Does a $250,000 cap assure better practice, better patient relations, say, than a $300,000 cap?

A I don't have any idea whether --

Q How about would a $200,000 cap be better than a 250?

A Well, I think, I think the answer to that is the data shows, I think convincingly, that the medical care in

California is excellent. And you have not heard, you have not heard horror stories out of California because doctors are abusing that number. And so I believe the only available data that can try to quantify that sort of judgment call strongly argues for a $250,000 cap.

Q Senator Villalobos yesterday read from a list of caps that exist around the nation. They range in all sizes and all forms.

A Right.

Q Have you seen the data of other states that suggest that a cap of $375,000 has accomplished the same thing, or that $450,000 has accomplished the same thing?

A I have heard anecdotally that in some of those states there are still problems and, again, this is anecdotal. I think some of those problems are that there are exceptions to the caps under some circumstances.

I think 25 years of data from California is just, is just unbeatable data, number one, about what has happened with the medical care in that state; and, two, whether patients are taken care of and, well, whether they are fairly compensated. And I would suggest to you that in no place more than California, if there were a popular outcry about poor medical care, that would have been changed a long time ago.

Q Mr. Meros, is it your position that --

SENATOR VILLALOBOS: Senator Smith, it is 12 o'clock.

We are going to take a break until one. We'll have you continue your testimony at one o'clock. We have got to eat, and I have got to go someplace else, so I will ask the Sergeant to please secure the room. We have documents on the table.

(Lunch recess taken).

STATE OF FLORIDA )

COUNTY OF LEON )

CERTIFICATE OF REPORTER

I, SUSAN WILLIS, CCR, RPR-CM, State of Florida; do hereby certify that I reported the foregoing proceedings at the time and place and in the cause indicated in the caption; that I later had the same reduced to written form by means of computer-aided transcription; and that the foregoing pages are the proceedings had before me as I was directed to transcribe.

I FURTHER CERTIFY that I am neither related to nor employed by any party to this litigation, or their counsel, and that I am not financially or otherwise interested in the outcome of this case.

WITNESS MY HAND AND SEAL at Tallahassee, Florida, this 17th day of July, 2003.

Susan Willis
MY COMMISSION # DD136786 EXPIRES
August 16, 2006
BONDED THRU TROY FAIN INSURANCE, INC.

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